



ATX Robotic Surgery

Dr Shey Ditto
11615 Angus Rd., Ste 106
Austin, Tx 78759

Dr Sudeep Burman
11615 Angus Rd., Ste 106
Austin, Tx 78759

Dr Adriana Castro
11615 Angus Rd., Ste 106
Austin, Tx 78759

PH: (512) 436-9986 FX: (512) 436-8295

Pharmacy and Primary Care Provider

Pharmacy:

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Number: _____

Primary Care Physician:

Primary Care Physician: _____

Address: _____

City/State/Zip: _____

If no PCP would you like to be referred to a PCP?

Patient Declined PCP Referral

Send New Patient Referral Out



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MEDICATION LIST

Currently on blood thinners? YES or NO
Medication Name:
Are you currently taking a compound semaglutide injection?
If yes, when was your last injection?
Are you on Ozempic, Mounjaro, Wegovy, Trizepitide, Zepbound, Trulicity?

Medication Name: (name, dose, how often)	Medication Name: (name, dose, how often)

Below List any Medications Allergic to

Medication	Reaction/Level of Severity



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MEDICAL HISTORY

Have you had or have you ever been diagnosed with any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> GERD	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Angina	<input type="checkbox"/> Goiter	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Migraine	<input type="checkbox"/> Stomach or Pepsid ulcer
<input type="checkbox"/> Arthritis Type:	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer Type:	<input type="checkbox"/> High Blood Pressure	Other Medical Conditions Below
<input type="checkbox"/> Cataracts	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> Colitis	<input type="checkbox"/> Jaundice	
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Stones	
<input type="checkbox"/> Diabetes Type:	<input type="checkbox"/> Liver Disease (type)	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Psoriasis	
<input type="checkbox"/> Gallstones	<input type="checkbox"/> Pulmonary Embolism	

Any Implantable Devices: _____